MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Examining the implications of the Medicare provisions of the BBA

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Statement of
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Subcommittee on Health,
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Good morning Chairman Thomas, Congressman Stark, members of the Committee. I am Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC), and I am pleased to participate in this hearing looking at refinements to the Medicare provisions in the Balanced Budget Act (BBA) of 1997. My testimony describes what we know and do not yet know about the implications of the BBA for Medicare beneficiaries, health care providers, and Medicare+Choice plans. I will also discuss recommendations that MedPAC has made this year and other options you may wish to consider.

The changes enacted in the BBA and implemented by the Health Care Financing Administration (HCFA) reduced Medicare payment rates relative to what they would have been otherwise for most providers and for Medicare+Choice plans in many areas. Not surprisingly, these changes have generated concerns among providers and health plans about their effects. Providers' and plans' concerns frequently have been heightened by their perception that the effects have been more harsh than the Congress intended, or that the effects, while intended, have nonetheless imposed burdens, and that there are specific problems with how HCFA has implemented the law.

Summary

A greater than expected slowdown in Medicare spending began in fiscal year (FY) 1998 and has continued this year. Medicare spending rose only 1.5 percent last year, compared with a projection of 5.7 percent by the Congressional Budget Office when BBA was enacted. Through the first 11 months of FY 1999, outlays ran about 1 percent below the FY 1998 rate for the same period.

Unfortunately, we cannot draw definitive conclusions about what the slowdown in spending means. Almost two years have gone by since the first BBA policies were put in place, but systematic data for this period are still extremely limited. Moreover, we cannot easily isolate the effects of the BBA from other changes in policy or market conditions. For example:

- Hospitals have argued that the changes in Medicare payments are reducing their margins and impinging on their ability to provide quality care. But the most recent complete information we have for the Medicare program is from FY 1997, the year before the BBA took effect.

- For home health services, we have seen lower than expected outlays, closures of home health agencies, and declines in the use of services. But our interpretation of these findings is clouded by other policy changes, notably efforts by HCFA and the Department of Justice to cut down fraud and abuse and by the lack of clear eligibility and coverage guidelines for home health care.

- Widely publicized withdrawals of plans from the Medicare+Choice program suggest that the program is not achieving the goals its authors intended. But managed care enrollment has continued to grow—albeit at a slower rate—since the BBA was enacted. Moreover, the pattern of withdrawals suggests that factors in addition to Medicare's payment rates are playing a role.

The BBA had ambitious objectives. For Medicare's fee-for-service program, it aimed to modernize payment systems and slow the growth in spending, while preserving Medicare beneficiaries' access to high-quality health care. For Medicare's managed care program, the BBA allowed new types of plans to participate and instituted new requirements intended to enable beneficiaries to choose more efffectively among their health plan options. To expect legislation this sweeping to achieve all of its objectives flawlessly is unrealistic. In some cases, targeted changes in statute or regulation could improve Medicare's payments and access to care for beneficiaries. But the complaints of providers and health plans notwithstanding, we have no evidence that wholesale changes in the BBA are either necessary or desirable.

How did the BBA change payments to providers?

The BBA enacted the most far-reaching changes to the Medicare program since its inception. The law reduced payment updates or otherwise slowed the growth in payments to virtually all fee-for-service providers. The law established, or directed to be established, new prospective payment systems for services provided by hospital outpatient departments, skilled nursing facilities, and home health agencies, and it revised the mechanism for updating fees for physician services. Finally, the BBA changed the way base payment rates are determined for health plans participating in the Medicare+Choice program and directed HCFA to implement a new system of risk adjustment that accounts for beneficiaries' health status.

Inpatient hospital services

The BBA changed payments for inpatient hospital services in a number of ways. For hospitals under Medicare's prospective payment system (PPS), the law provided for no update to operating payments in FY 1998 and limited updates from FY 1999 through FY 2002. It required phased reductions in the per-case adjustments for the indirect costs of medical education (IME) and, temporarily, for hospitals serving a disproportionate share (DSH) of low-income patients. And it instituted a new transfer policy for 10 high-volume diagnosis related groups (DRGs), reducing the payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.

By themselves, lower updates would have slowed the growth in payment rates to hospitals for inpatient services but would not have reduced them. In FY 1998, however, the combined effect of the freeze on payment rates, smaller IME and DSH payment adjustments, and a small decline in the case mix index reduced payment rates in absolute terms. Payment rates should begin to increase again in FY 1999, albeit at a slower rate than would have occurred in the absence of the BBA.

Outpatient hospital services

In addition to changes in payments for inpatient services, the BBA also enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment under which Medicare's payments did not correctly account for beneficiaries' cost-sharing and extended the reduction in payments for services paid on a cost-related basis. The law also directed the Secretary to establish a prospective payment system for services that have been paid at least partially on the basis of incurred costs.

Hospitals have not yet felt the full impact of the BBA provisions affecting outpatient services. MedPAC estimates that elimination of the formula-driven overpayment, which took effect in 1998, reduced payments by about 8 percent. However, the PPS that was to have gone into effect in January 1999 will not be put in place before next summer. HCFA originally estimated that the PPS would reduce payment rates by 3.8 percent, on average, but has since revised its estimate of the reduction to 5.7 percent. These estimates likely overstate the ultimate reduction, however, as hospitals will have an incentive to code outpatient services more accurately than they do now.

Services in skilled nursing facilities

The BBA enacted a PPS for services provided in skilled nursing facilities (SNFs). These services had previously been paid on the basis of costs, subject to limits on routine services. Under the new system, payments are intended to cover the routine, ancillary, and capital costs incurred in treating a SNF patient, including most items and services for which payment was previously made under Part B of Medicare. Patients in SNFs are classified under the Resource Utilization Group system, version III (RUG-III), which groups patients by their clinical characteristics for determining per diem payments.

The new payment system slows spending growth for SNF services by moving these facilities from cost-based reimbursement to federal rates that are based on average allowable per diem costs in FY 1995, trended forward using the increase in the SNF market basket index less 1 percentage point. Because nursing home spending—particularly for ancillary services—grew rapidly between FY 1995 and FY 1997, using FY 1995 as the base for payment purposes reduced payments for many nursing homes. The PPS is being phased in over a four-year period that began in 1998. Payments in FY 1999 are based on a 50/50 blend of federal rates and facility-specific rates and will be based entirely on the federal rates beginning in FY 2001.

Home health services

Before the BBA, home health agencies were paid on the basis of costs, subject to limits based on costs per visit. The BBA directed the Secretary to implement a prospective payment system effective October 1999—since delayed by the Congress to October 2000—and established an interim payment system (IPS) intended to control the growth in spending until the PPS was in place. The IPS reduced the limits based on costs per visit and introduced agency-specific limits on average costs per beneficiary based on a blend of agency-specific costs and average per-patient costs for agencies in the same region. Home health agencies are now paid the lower of their actual costs, the aggregate per-beneficiary limit, and the aggregate per-visit limit. Agencies' per-beneficiary limits are based on their average costs per beneficiary in FY 1994, trended forward using the home health market basket index. As with nursing homes, home health spending grew rapidly in the mid-1990s. For this reason, using FY 1994 as a base for payment led to substantial payment cuts for some home health agencies.

Physician services

The BBA replaced the volume performance standard system that had been used to update physicians' fees with a new sustainable growth rate (SGR) system. It also introduced a single conversion factor for

all physician services that reduced payments for some services while increasing them for others. Finally, the BBA established requirements for payments to physicians for their practice costs.

Unlike some of the other provisions of the BBA, changes to Medicare's payments to physicians occurred almost immediately. Starting on January 1, 1998, the single conversion factor was implemented along with the first step toward revising practice cost payments. The effects of these changes were largest for some surgical procedures, such as cataract surgery and some orthopedic procedures, where payment rates fell by 13 percent or more. Payment rates for other services went up, however. Payments for office visits and some diagnostic services increased by at least 7 percent.

Medicare+Choice plans

Before enactment of the BBA, Medicare's payments to private health plans participating in the section 1876 risk contracting program were based on the average payments made on behalf of beneficiaries in its traditional fee-for-service program living in the same county. The BBA severed the link between county-level trends in fee-for-service spending and payment updates to plans by instituting a floor under county payment rates, blending local and national payment rates (subject to a so-called budget-neutrality provision), and removing the component of base rates attributable to spending for graduate medical education. Overall, the law limited updates to payment rates in all counties by slowing the rate of growth in national fee-for-service spending and by subtracting a specified factor from that rate. The blending policy raised updates in some counties but reduced updates in others.

In addition to changes in base payment rates, the BBA required HCFA to implement a new system of risk adjustment that takes into account the health status of the beneficiaries that plans enroll. The law laid out a very tight time schedule, requiring HCFA to implement the new system by January 1, 2000. The system that HCFA has proposed will raise payments for certain enrollees who were hospitalized in the year preceding the payment year and will reduce payments for other enrollees. The amount of the higher payments will depend on the principal diagnoses associated with hospital admissions. HCFA has

proposed to phase in the new system over a five-year period and has estimated that other things being equal, the new system would reduce payment rates by 7.6 percent on average at the end of the phase-in.

What has been the impact of these payment changes?

Providers' and plans' concerns are clearly relevant to any assessment of the BBA. But at the same time, we must remember that the primary objective of the Medicare program is to maintain access to high-quality care for beneficiaries. Assessing the implications of the BBA should therefore focus on whether access to or quality of care has been hampered and, if so, what can be done about it.

In evaluating the potential impact of the BBA on access and quality, two issues seem especially important. One is how policies may interact to affect providers' ability and incentives to furnish care. Hospitals, for example, often furnish many types of services and must therefore face the combined effects of policy changes that have altered payments for virtually every service they provide. Medicare+Choice plans face changes in the way base payment rates are calculated, new requirements for participation, and future changes in payments arising from the introduction of a new risk adjustment system.

A second issue is whether the new payment systems adequately reflect predictable differences in patient care costs. Industry and other analysts have raised this issue with regard to the IPS for home health agencies and the prospective payment systems being developed for outpatient hospital services and being phased in for SNFs. Where predictable differences in costs are not taken into account, financial incentives are created for providers to deny access to care or undertreat identifiable groups of patients.

Sorting out the effects of multiple changes in payment policies and the introduction of new payment systems on beneficiaries' ability to obtain the medical services they need is challenging in two important respects. First, many BBA changes have not yet been fully phased in, and data to evaluate the impact

of recent changes are in many cases not yet available. Second, measuring access to care is difficult. Because directly measuring appropriate beneficiary use of services is hard to do with existing data, policymakers often look at determinants of access, such as provider availability and willingness to serve Medicare beneficiaries, as well as the nature and extent of other barriers to access that beneficiaries face. Interpreting the findings of these analyses can be difficult, however, because we cannot isolate the effects of changes in Medicare policy from the effects of other changes in health care financing or delivery arrangements.

Financial impacts

During the past year, various indicators have been cited as measuring the financial impact that the BBA is having on providers. The hospital industry, for example, has issued several reports analyzing the impact of the BBA on hospital revenues and margins. A second example is the closures of home health agencies since the IPS was put in place. The home health industry and its observers claim that the IPS caused declines in the number of agencies, putting beneficiaries' access to home health care services at risk.

Hospitals. The reports issued by the hospital industry contain new projections, but they do not present new data. In response to congressional requests, MedPAC staff has analyzed these projections and found that all of them portray a more adverse impact of the BBA than we believe to be the case. Some present a particularly inaccurate picture of the impact in FY 1998 by assuming a rate of increase in costs that substantially exceeds what we already know to have occurred. Data from the American Hospital Association's National Hospital Panel Survey suggest that when complete Medicare cost report data become available later this year, we will again see a decline in Medicare cost per discharge for FY 1998, the fifth year in succession.

Although we believe that industry reports somewhat overstate the impact of the BBA on hospital margins, they do correctly present its overall direction. As it was intended to do, the law has reversed a

six-year trend of Medicare payments rising more rapidly than the costs of treating Medicare beneficiaries. Still, two reasons make it difficult to interpret what changes in total margins mean for Medicare policy. First, the financial pressure that hospitals are currently experiencing reflects both changes in Medicare's payment policies and continued strong downward pressure on revenues from private managed care plans and other payers. In FY 1997, private payers' payments dropped by 4 percentage points relative to the cost of treating their patients, while Medicare payments rose relative to costs. Data for FY 1998 are not yet available, but we have every reason to believe that the downward pressure from private payers continued as Medicare reduced its payments. Second, because hospitals can be expected to continue responding to financial pressures by slowing cost growth—the overall increase in costs per case for all patients has been below 2.5 percent for five straight years—projected margins serve only as a gauge of financial pressure, not as a prediction of what will occur. MedPAC has seen no convincing evidence that the changes to date have affected either quality or access in the inpatient sector, but we will continue to monitor developments.

Home health agencies. To examine whether the closures of home health agencies may have affected beneficiaries' access to services, the General Accounting Office (GAO) analyzed the distribution of closures across urban and rural counties. The agency also interviewed stakeholders—representatives of state agencies, beneficiary advocates, hospital discharge planners, and managers of home health agencies—in 34 primarily rural counties that had experienced significant agency closures or declines in the use of services. GAO concluded that the closures have had little impact on Medicare beneficiaries to date. However, the agency noted that beneficiaries who are more costly than average may face difficulty in obtaining home health care in the future as agencies change their behavior in response to the IPS.

The GAO study found that while about 14 percent of agencies had closed between October 1, 1997, and January 1, 1999, more home health agencies were in existence at the beginning of FY 1999 than at the beginning of FY 1996. The study found that most of the closures occurred in urban counties and

that about 40 percent of the closures occurred in three states—Louisiana, Oklahoma, and Texas—that had seen a large expansion in the number of agencies and that had utilization rates well above the national average.

Stakeholders interviewed by the GAO reported few access problems currently. State survey agency representatives, for example, indicated that adequate capacity continued to exist despite the closures and reported that they had received few complaints about access to Medicare home health care. Discharge planners and home health agency managers reported that beneficiaries living in counties that had lost agencies still had adequate access through agencies located in adjacent counties.

Willingness to serve beneficiaries

Industry and policy analysts have expressed concerns about the case-mix adjuster used in the new PPS for SNFs, the lack of case-mix adjustment in the IPS for home health agencies, and about the new system for determining physicians' fees. In the Medicare+Choice program, questions center around whether the lack of participation by new plans and withdrawals by existing plans reflect payment levels or other factors.

Skilled nursing facilities. In the case of SNFs, concerns have centered around the payment weights used in conjunction with the RUG-III system. Although SNF patients can vary significantly in their use of ancillary services and supplies such drugs and biologicals, payments for patients in different RUG-III categories are based on estimates of the time providers's staff spent furnishing nursing and therapy services. SNFs may be unwilling to serve patients in some high-acuity RUG-III groups for whom the costs of services may exceed the payment rates.

The Office of the Inspector General (OIG) of the Department of Health and Human Services has undertaken a study to assess these concerns. The OIG surveyed a random sample of 200 hospital

discharge planners responsible for arranging nursing home care for patients being discharged from hospitals.

The OIG report concluded that while serious problems in placing Medicare beneficiaries in nursing homes are not apparent, SNFs are changing their admitting practices in response to the new payment system. Two-thirds of discharge planners responding to the survey reported no difficulty in placing Medicare patients. At the same time, almost half of the discharge planners surveyed reported that nursing homes have begun requesting more detailed clinical information about patients and more often assessing patients directly before making admissions decisions.

The survey found that some patients have become harder to place, including those who need extensive services, such as intravenous feedings or medications, tracheostomy care, or ventilator and respirator care. These findings are consistent with concerns that payment weights under the PPS do not account adequately for certain medically complex patients.

Home health agencies. The IPS for home health agencies has been criticized because the aggregate per-beneficiary limit is based on historical patterns of use and does not account for changes in agencies' patient mix. Industry and beneficiary representatives have asserted that this limitation has made home health agencies unwilling to accept patients who are likely to need extensive services. To assess these concerns, MedPAC contracted with Abt Associates, Inc., to survey about 1,000 home health agencies in early 1999 on their experience under the IPS. We also convened a panel of experts familiar with beneficiaries' problems accessing home health services.

The results of our survey of home health agencies are consistent with the preliminary information we have on utilization. The agencies we surveyed generally reported that their Medicare caseloads have fallen and that the number of visits per user they provide has decreased. Almost half reported that they had changed the mix of services they provide, with fewer aide visits being the most common response. While virtually all of the agencies we surveyed reported that they are accepting new patients, the share

accepting all new Medicare patients was 75 percent, compared with 85 percent before the IPS was implemented. About 40 percent of agencies reported a change in admissions practices—refusing to admit patients that they would have accepted before the IPS—and 30 percent reported discharging patients because of the IPS. Agencies most frequently identified long-term or chronic care patients as those they no longer admitted or have discharged.

These findings are consistent with the claim that the IPS has hampered access, but they do not tell the whole story because the change in payment policy occurred at the same time HCFA was implementing other policies intended to reduce fraud and abuse, including stepping up oversight of home health care providers and imposing a four-month moratorium on the certification of new agencies in early 1998. The agency also adopted a new procedure for processing claims for home health care services. Assessing the effect on beneficiaries of changes in home health agencies' willingness to serve them is further confounded because we cannot determine whether the changes in use of home health services observed during the past two years are appropriate. Medicare's standards for eligibility for and coverage of home health services are too loosely defined for us to do so.

Physician services. Three aspects of the new mechanism for setting physicians' fees have raised questions regarding their impact on access. First, the introduction of a single conversion factor reduced payment rates for surgical services, while payment rates for primary care and other nonsurgical services generally increased. Second, the Secretary's lack of authority to correct for projection errors and the potential for oscillations in fee updates under the SGR system have raised questions about whether updates are appropriate. Because the SGR is cumulative, uncorrected projection errors affect all subsequent updates. This happened in 1999, when an unexpected slowdown in Medicare+Choice enrollment growth led to a smaller than projected decline in Part B fee-for-service enrollment. Third, the SGR system as currently designed has the potential for oscillation in fee updates because of problems with the data and methods used to calculate the updates. These problems are likely to lead to extreme positive and negative updates.

To assess the effects of the payment changes introduced in 1998, MedPAC contracted with Project HOPE to survey 1,300 physicians on their willingness to serve Medicare beneficiaries. The survey data were reassuring. Among physicians accepting all or some new patients, over 95 percent were accepting new Medicare fee-for-service patients both in 1997, before the new payment policy changes were implemented, and in early 1999. The survey also found that only about 10 percent of physicians reported changing the priority given to Medicare beneficiaries seeking an appointment. Of those, the percentage giving Medicare patients a higher priority was almost the same as the percentage giving Medicare patients a lower priority.

Medicare+Choice plans. The Congress intended the Medicare+Choice program to expand beneficiaries' health plan options, but this has not occurred. Plan participation has decreased from a year ago: of 347 contracts HCFA had with risk plans in 1998, 99 of those plans withdrew from serving at least one county, and many withdrew from the Medicare+Choice program altogether. This coming January, another 99 contracts will either be canceled or modified to reduce service areas. At the same time, however, enrollment in Medicare+Choice plans has continued to grow. Despite a brief dip in growth earlier this year, enrollment in these plans has grown by 6.5 percent (about 400,000 enrollees) since a year ago.

Payment levels are ultimately an important determinant of plan participation. However, payment levels alone do not yet appear to have had much impact either in encouraging new plans to enter the market, or inducing existing plans to leave. For example, despite the introduction of the floor and blend payments, we have not seen plan participation expand significantly in counties that benefitted from those provisions. Similarly, plan withdrawals have been disproportionately lower in counties where payment growth has been most constrained. Instead, plans' reluctance to participate may stem from concerns about regulatory issues and about the anticipated impact of risk adjustment on payments in coming years.

Where do we go from here?

Although there is no systematic evidence to date that beneficiaries' access to care has been impaired, the vast number of changes to Medicare payment policy introduced by the BBA make it more important than ever to monitor access. In our March and June reports to the Congress, MedPAC noted where we believe policy changes are not yet warranted and recommended specific targeted policies that could help to alleviate some of the concerns that have been raised regarding access to care in the future.

Hospital inpatient services

In our March report, MedPAC concluded that the operating update for FY 2000 enacted in BBA—1.8 percentage points less than the increase in HCFA's operating market basket index or 1.1 percent—will provide reasonable rates. In formulating our recommendation, MedPAC took into account part, but not all, of the cumulative reduction in costs per case that has occurred. We noted that hospitals have responded to an increasingly competitive market by improving their productivity and by shifting services to other sites of care. At the same time, we recognized factors pointing to the need for caution in specifying future updates, including emerging evidence that the decade-long trend in rising case mix complexity, which automatically increases PPS payments, may be subsiding. We also questioned whether the unusually low rate of hospital cost growth observed in recent years can be sustained without adverse effects on quality of care.

Hospital outpatient services

MedPAC has concerns about the PPS proposed by HCFA for hospital outpatient services. In basing payments on groups of services, instead of individual services, the system is likely to overpay for some services and underpay for others. This could lead to access problems in the future for beneficiaries needing services whose payments fall short of costs. In our March report, MedPAC recommended that the PPS be based on the costs of individual services. Since that recommendation was made, HCFA has been collecting comments on its PPS proposal, with the formal comment period ending

July 30, 1999. HCFA will review the comments with the assistance of a private contractor, 3M Health Information Systems. HCFA then plans to issue a final regulation at least 90 days before the PPS is implemented.

Implementing the outpatient PPS will reduce payments for virtually all hospitals but could have much larger effects on specific types of hospitals. For example, based on HCFA's original estimates—which do not take into account improvements in coding that will lead to smaller reductions—small rural hospitals would see a 17 percent decline in payment rates, and cancer hospitals would see a drop of more than 30 percent. Given these changes, MedPAC recommended that the Secretary closely monitor the use of hospital outpatient services to ensure that beneficiaries' access to appropriate care is not compromised. Consideration should also be given to phasing in the new payment system to help us detect any problems before they become severe.

Skilled nursing facilities

The OIG report on the willingness of SNFs to continue accepting Medicare beneficiaries provides some comfort that early anecdotal reports of access problems do not indicate a widespread problem. Nonetheless, MedPAC remains concerned about the mismatch between payments and costs for patients who require relatively high levels of nontherapy ancillary services and supplies could hamper access in the future. In our March report, we recommended that the Secretary continue to refine the classification system to improve its ability to predict the use of nontherapy services and supplies. An improved classification system would match payments more closely to beneficiaries' needs for services and help to avoid access problems among medically complex patients. HCFA has indicated that it is researching the adequacy of payments under the PPS and will implement refinements next year if that research indicates changes are warranted.

Home health services

Implementing a PPS for home health care services that accounts for differences among beneficiaries will help to ensure access for those who require extensive care. MedPAC is concerned, however, that the timetable for implementing the PPS is very tight. Accordingly, we recommended in our June report that the Congress explore the feasibility of establishing a process for agencies to exclude a small share of their patients—say 2 percent—from the aggregate per beneficiary limits. Under our recommendation, Medicare would reimburse care for excluded patients based on the lesser of actual costs or the aggregate per-visit limits. MedPAC believes that such a policy should be implemented in a budget-neutral manner.

In the longer run, ensuring that Medicare beneficiaries have access to appropriate home health care services will require clarifying the benefit. To that end, MedPAC recommended that the Secretary speed the development of regulations that would outline home health care coverage and eligibility criteria based on the clinical characteristics of beneficiaries and that she recommend to the Congress the legislation needed to implement those regulations.

Physician services

In part because of their technical nature, problems with the sustainable growth rate system that determines updates to payments for physicians' services have received less publicity than concerns about facility payments. But because uncorrected projection errors and wide swings in payment updates could raise access problems in the future, MedPAC recommends that the Congress require the Secretary to correct estimates used in SGR system calculations every year and that legislation be enacted to modulate swings in updates. Further, we recommend that the Congress revise the SGR to include an allowance for cost increases due to improvements in medical capabilities and advancements in scientific technology.

Medicare+Choice plans

In our March report, MedPAC recommended that the Secretary work with organizations offering plans to identify specific regulations or program policies for which changes, delays in implementation, or administrative flexibility could reduce the burden of compliance without compromising the objectives of the Medicare+Choice program. Two specific changes that we noted—moving back the deadline for filing adjusted community rate proposals and giving Medicare+Choice organizations the flexibility to tailor their benefit packages within their services—have already been done.

The Commission also made recommendations concerning HCFA's proposed system of risk adjustment. Although the interim risk adjustment proposal has important shortcomings, we believe it represents a substantial improvement over the current method and that its benefits outweigh its costs. We support phasing in the new system because doing so will avoid large abrupt changes in payments to Medicare+Choice organizations and will give policymakers time to monitor and evaluate the interim system's effects on organizations and beneficiaries. Given its limitations, the interim risk adjustment method should be replaced as soon as possible by a comprehensive method based on enrollees' encounters in all settings, not just inpatient.